SD EForm -1002 V3

Complete and use the button at the end to print for mailing.

HELP

DSS-EA-301M 06/05
South Dakota Medical

SOUTH DAKOTA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) / MEDICAL ASSISTANCE APPLICATION

This form is used to apply for FREE health coverage for children under the age of 19. It may also be used for FREE health coverage for pregnant women and families with children. If you have questions, contact your local Social Services Office. If more space is needed, please use a separate sheet of paper and report the information as it is listed on this form. State and federal laws prohibit discrimination in all Department of Social Services' programs and activities on the basis of race, color, national origin, gender, religion, age, disability and political beliefs. (Not all prohibited bases apply to all programs.) To file a complaint of discrimination write Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501 or call (605) 773-3305.

INSTRUCTIONS:

1. Read this application form carefully and **answer each question completely**.
2. If you need help completing or understanding this form, contact the Department of Social Services in the County where you live.
3. **Provide proof of income, insurance, and daycare or child support expenses**. You do not have to send original documents, copies are okay.
4. Sign and date the application form. (If two parents are in the home, both must sign)
5. Mail, Fax, or take the application form to your local Social Services Office. A determination will be made within 45 days from the date your application is received.

1. Tell us who you are and where you live:

First Name	Initial	Last Name	Maiden Name or Other Name (if any)
Mailing Address			Please give us a phone number where we can call you if we have questions about your application form.
			Home Phone: Work Phone:
Directions to reach your home if rural:			
City, State, Zip Code			Other Phone:
	SD		

I understand that by applying for and accepting medical assistance, I assign any rights to Medical support, insurance proceeds or both that the applicant or recipient may have. I understand that information given will be matched by computer with the records of other agencies such as Social Security or Internal Revenue Services (IRS). I understand that State and Federal law provide for fine, imprisonment, or both for any person guilty of receiving assistance which he/she is not entitled to by withholding or giving false information. I understand the penalty for perjury is a fine of up to $5000, a sentence of up to five years in prison, or both.

_____ Date ____ /____ /____
Sign

CONSENT TO RELEASE INFORMATION

I give my consent for any person, agency or institution to supply information to the Department of Social Services about me or my family, and to allow inspection and copying of records about me or my family by any representative of the Department. I authorize the Department to release information to providers, State, or Federal agencies. This consent is given only for use by the Department in administration of its programs. It continues until I state in writing that it is no longer valid. I release any person, agency, or institution from any legal responsibility to me or my family for supplying such information.

_____ Date ____ /____ /____
Sign

_____ Date ____ /____ /____
Sign Spouse / Other Parent in home

This box for office use only

Date Received | Case Number

2. Tell us who lives in the home:

Starting with the person filling out this form. *Completion of Race, Social Security Number (SSN), and citizenship is optional for persons NOT asking for CHIP/Medical assistance.

First Name Initial Last name	CHIP/ Medical Asst. Wanted	Format 99/99/9999 Date of Birth	*Race/Ethnicity (Check all that apply)	Relationship to person filing out this form (Spouse, Friend, Child, etc.)	*U.S. Citizenship	Sex
 Last Grade Completed ______________	☐ Yes ☐ No	________________ Social Security Number ________________	Hispanic or Latino ☐ Yes ☐ No ☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black	SELF	☐ Yes ☐ No Primary Language ☐ English ☐ Spanish ☐ Other	☐ Male ☐ Female
First Name Initial Last Name Last Grade Completed ______________	☐ Yes ☐ No	________________ Social Security Number ________________	Hispanic or Latino ☐ Yes ☐ No ☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ Yes ☐ No Primary Language ☐ English ☐ Spanish ☐ Other	☐ Male ☐ Female
First Name Initial Last Name Last Grade Completed ______________	☐ Yes ☐ No	________________ Social Security Number ________________	Hispanic or Latino ☐ Yes ☐ No ☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ Yes ☐ No Primary Language ☐ English ☐ Spanish ☐ Other	☐ Male ☐ Female
First Name Initial Last Name Last Grade Completed ______________	☐ Yes ☐ No	________________ Social Security Number ________________	Hispanic or Latino ☐ Yes ☐ No ☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ Yes ☐ No Primary Language ☐ English ☐ Spanish ☐ Other	☐ Male ☐ Female
First Name Initial Last Name Last Grade Completed ______________	☐ Yes ☐ No	________________ Social Security Number ________________	Hispanic or Latino ☐ Yes ☐ No ☐ Am. Ind. ☐ White ☐ Hawaiian ☐ Asian ☐ Black		☐ Yes ☐ No Primary Language ☐ English ☐ Spanish ☐ Other	☐ Male ☐ Female

3. Tell us about health insurance:

YES ☐ **NO** ☐ Do any of the persons wanting CHIP/medical assistance have health insurance coverage?

(ATTACH PROOF OF OTHER INSURANCE, SUCH AS AN INSURANCE CARD (FRONT & BACK) OR STATEMENT OF BENEFITS IF COVERAGE EXISTS, INCLUDE INSURANCE FROM A FOREIGN COUNTRY.)

List the person asking for CHIP/medical assistance with Insurance	Insurance Format 99/99/9999 Start date End date	Name & Address of Insurance Co.	Name of Employer with insurance (if any)	Policy/Group # Insurance Type	Name of Policy Holder
____________________ ____________________ ____________________	____________________ ____________________ ____________________			# ________________ ☐ Inpatient & Outpatient ☐ Pharmacy ☐ Vision ☐ Inpatient Only ☐ Dental ☐ Outpatient Only ☐ Excludes Pregnancy Coverage ☐ Other______________	____________ Doe this parent live in the home? ☐ Yes ☐ No

YES ☐ **NO** ☐ Did anyone recently lose a job and group health insurance?

If yes, name of employer ________________________________ Date insurance ended ____________________

YES ☐ **NO** ☐ Has anyone dropped group health insurance within the past 3 months?

If yes, list name(s) ________________________________Reason for dropping___________________________

YES ☐ **NO** ☐ Is any child asking for CHIP/medical assistance eligible to be enrolled in State employee insurance with a parent they live with?

YES ☐ **NO** ☐ Did anyone asking for CHIP/medical assistance receive medical care in the last 3 months?

If yes, list name(s) ________________________________Date of medical care **(Month/Year)** ____________________

(ATTACH PROOF OF INCOME FROM MONTH(S) WHEN MEDICAL CARE WAS RECEIVED IF WITHIN LAST 3 MONTHS)

4. Tell us:

YES ☐ **NO** ☐ Is anyone asking for pregnancy medical converge? **If yes, list name of pregnant person(s) and expected due date**

_____ _____
Name Due Date Month/Year

YES ☐ **NO** ☐ If requesting pregnancy medical coverage, is there a plan for surrogacy or adoption? **(IF YES, PROVIDE ANY AGREEMENT REGARDING COVERAGE OF MEDICAL EXPENSES.)**

Please list any income for all people living in the home. For a child living with someone other than a parent, only list the child's income. For a pregnant woman 18 or older, do NOT list her parent's income.

5. Tell us about income:

YES ☐ **NO** ☐ Is anyone over 18 working? (If yes, please complete the following for every job)
(ATTACH PROOF OF ALL CURRENT WAGES SUCH AS PAY STUBS OR A LETTER FROM YOUR EMPLOYER FOR EACH JOB FOR THE LAST 30 DAYS. ENTER GROSS PAY, NOT TAKE HOME PAY)

First Initial Last Name	Where do you work?	Hours per week and Wage per hour	How Often Paid	Total GROSS $ (Include tips each month)
			☐ weekly ☐ monthly ☐ every two weeks ☐ twice a month	$
			☐ weekly ☐ monthly ☐ every two weeks ☐ twice a month	$
			☐ weekly ☐ monthly ☐ every two weeks ☐ twice a month	$

YES ☐ **NO** ☐ Is anyone self-employed?
If yes, type of work_____. You must provide the most recent completed and signed tax forms. (Provide entire form). If you do not have tax forms, business ledgers or office records will be needed.

YES ☐ **NO** ☐ Does someone get income that is not from a job?
(**ATTACH PROOF OF INCOME**.) Examples of income to list are Social Security, Child Support, GA, interest income, SSI, etc.

First Initial Last Name	Type of Income	How Often Received	Total GROSS $ you expect this month
		☐ weekly ☐ monthly ☐ twice a month ☐ other	$
		☐ weekly ☐ monthly ☐ twice a month ☐ other	$
		☐ weekly ☐ monthly ☐ twice a month ☐ other	$

6. Tell us about expenses:

YES ☐ **NO** ☐ Does anyone pay child support?
If yes, who pays _____How much is paid each month $_____
Who is child support paid to_____.
(ATTACH PROOF UNLESS PAID TO SOUTH DAKOTA CHILD SUPPORT OFFICE)

YES ☐ **NO** ☐ Does anyone pay child care so they can work?
List only the amount actually paid. Do not list the amount paid by child care assistance or some other source.
(ATTACH PROOF OF CHILD CARE PAID)

Name of child First Initial Last Name	Amount paid	How often paid	Name of person who pays child care First Initial Last Name	Name of Daycare or babysitter
	$	per		
	$	per		
	$	per		

IMPORTANT: If you are only applying for medical assistance for children, stop here.
DO NOT complete page 4 if applying for children only. Complete page 4 if applying for coverage of pregnancy or if an adult relative caring for a child is also applying for medical assistance.

IMPORTANT: Fill out this page ONLY if applying for pregnancy coverage or if an adult relative caring for a child is also applying for medical assistance.

7. Tell us about resources:

List all resources of parent(s) or other caretaker relatives of children under age 19 or woman applying for pregnancy related coverage. If married, list spouse's resources (please mark yes or no for each box below) Examples of resources are listed below.

(Use a separate line for each individual if more than one has the same type of resource.)	YES	NO	If yes, Value	Owner(s) (List all Co-owners) First Initial Last Name	Name and address of resource location	Account Number
Cash on Hand	☐	☐				
Checking Account (banks, credit unions)	☐	☐				
Savings Account (bank, credit unions)	☐	☐				
Certificate of Deposit (CD)	☐	☐				
IRA/Keogh/401K	☐	☐				
Money Market Funds	☐	☐				
Stocks	☐	☐				
Bonds	☐	☐				
IIM Account	☐	☐				
Burial Account	☐	☐				
Trust Funds	☐	☐				
Contract for Deed	☐	☐				
Life Estate	☐	☐				
Safe Deposit Box	☐	☐				
Whole Life Insurance (not Term Insurance)	☐	☐				
Uniform Transfer to Minor Account	☐	☐				
Savings Bonds	☐	☐			Type of Bond	Issue Date
Savings Bonds	☐	☐			Type of Bond	Issue Date
Other	☐	☐				

Resource	YES	NO	Owner(s) (List all Co-owners) First Initial Last Name	Year, Make, & Model	Value	Amount Owed
Car	☐	☐				
Car	☐	☐				
Car	☐	☐				
Car	☐	☐				
Truck	☐	☐				
Truck	☐	☐				
Boat	☐	☐				
Snowmobile	☐	☐				
Camper	☐	☐				
Motorcycle	☐	☐				
Other Vehicle	☐	☐				
Farm Equipment	☐	☐				
Livestock	☐	☐				
Other	☐	☐				

Property	YES	NO	Owner(S) (List all Co-owners) First Initial Last Name	Property Location	Value	Amount Owed
House	☐	☐				
Mobile Home	☐	☐				
Land	☐	☐				
Building	☐	☐				
Other	☐	☐				

7a. If you listed a house or mobile home, is this where you live? YES ☐ NO ☐

Remember to sign and date the Front Page.

PRINT FOR MAILING CLEAR FORM